

Sample Compassionate Care Visit Review Worksheet

This sample review template is based on (<https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf>). This sample is intended as a tool to inform the development of facility specific policies and does not reflect state or local guidance. As guidance can change frequently during a pandemic, it is the responsibility of the facility to ensure that the most current guidance from federal, state and local entities is being followed. Reasons listed for compassionate care visits are provided as sample reasons and are not all-inclusive.

Tips for using this tool:

- Prior to each review, verify the worksheet has been updated to reflect the most current federal, state, and local guidance including guidance on what is considered a reasonable clinical or safety cause for denial of a request.
- Review resident’s chart to ensure team is familiar with signs and symptoms or risks that align with intent of the compassionate care visit guidance.

Resident Name:		DOB:		Location:	
Name of individual requesting the visit: _____ <input type="checkbox"/> Family Member <input type="checkbox"/> Clergy or Lay Person providing religious or spiritual support: <input type="checkbox"/> Ombudsman <input type="checkbox"/> Other individual who can meet resident needs (describe):				Date of Review:	
REVIEW PARTICIPANTS					
<input type="checkbox"/> Ombudsman (check box if present)		<input type="checkbox"/> (pre-populate with team member name check box if present)		<input type="checkbox"/> (pre-populate with team member name check box if present)	
REASON GIVEN FOR COMPASSIONATE VISIT REQUEST (check all reasons cited by requester)					
<input type="checkbox"/> End of Life		<input type="checkbox"/> Difficulty adjusting to new environment		<input type="checkbox"/> Resident grieving death of family member or friend	
<input type="checkbox"/> Resident weight loss or dehydration when cueing/ encouragement previously provided by family		<input type="checkbox"/> Emotional distress with increased frequency of crying or decreased speaking			
<input type="checkbox"/> Other (please explain):					
REVIEW FINDINGS					
<input type="checkbox"/> Meets criteria, visit approved		<input type="checkbox"/> One Occurrence <input type="checkbox"/> Weekly <input type="checkbox"/> Other Frequency (define): <input type="checkbox"/> Individual assigned to educate patient and visitor on guidelines for the visit (e.g., infection control guidelines, schedule, location)			
<input type="checkbox"/> Does not meet criteria, visit not approved		Brief explanation of why request does not meet compassionate care visit criteria:			
Date of Next Review:					
Feedback from individual requesting the visit:					